



THE
CALIFORNIA HOMŒOPATH.

VOL. VI.

JULY, 1888.

No. 7.

ORIGINAL ARTICLES.

A FEW DESULTORY REMARKS ON SURGERY IN
GENERAL, AND CONSERVATIVE SURGERY IN
PARTICULAR.

By JOHN J. MILLER, M. D., SAN JOSE.

[*Read before California State Homœopathic Society, 1888.*]

The word "conservative" as used to define or limit the noun "surgery," is here almost synonymous with preservative, that is, it is surgery which conserves or preserves life and limb.

It is not used in the common acceptance of the term, which means the tendency to preserve what is established, the opposition to change and the disposition to maintain existing institutions in thought and action.

Conservatism as applied to surgery, does not mean "expectancy," that last resort of the medical attendant who, not being exactly clear as to the proper treatment to be pursued, waits like Micawber for "something to turn up." On the contrary, conservatism may often imply active interference and operative measures on the part of the surgeon. But it does mean, first, the preservation of life always; and secondly, the preservation of a limb or an organ by the employment of any

or all the measures we have at our control for securing that end. It means painstaking effort for the attendant, extending, it may be, over months in his endeavor to save a foot, instead of the easier amputation done at once; the use of skin or sponge grafting in a large, deep burn to prevent contraction of the hard cicatricial tissue; the removal of a tumor or foreign body which is pressing on some noble organ, and thereby destroying its function. Thus all surgery is in one sense conservative, but it is considered particularly so at the present in that class of cases which, under old treatment, demanded the sacrifice of a part in order to save the whole; the sacrifice of a limb to preserve a life, as being the lesser of two evils, but which, under the new dispensation, we are enabled by careful, long-continued effort, and a strict attention to details to conserve the whole.

The science and art of surgery has made a more notable and rapid advance within the last twenty years than that of medicine. I do not say that there has been no medical advance, but the changes for the better in surgical practice have been more memorable and striking in their effects, and in some departments of general surgery might almost be called revolutionary.

The direct and indirect results of writings and teaching of Joseph Lister we do not as yet completely realize. He and his followers have opened up for us at least three new fields where surgeons before his day did not dare to penetrate—the abdominal cavity, the pleural cavity, and the large joints, besides simplifying the treatment of all wounds, saving the patient's strength and the surgeon's time; causing them less pain and the surgeon less anxiety. Dr. George Jackson Fisher, in an article on the History of Surgery, says: "In the whole domain of surgery there is nothing at all comparable with the contributions of J. Marion Sims in gynecology." As another example of improvement in surgical procedures I would cite Bigelow's comparatively new operation of "litholapaxy," which has already greatly modified our views and treatment of stone in the bladder.

There are now a number of diseases that are classed as distinctly belonging to the surgeons sphere, that a short time ago received a purely medical treatment, at least medi-

cal treatment or expectancy which is still a well recognized method in therapeutics.

Among these can be mentioned tumors or abscesses of the brain, in fact anything pressing on the brain mass, clots of extravasated blood, etc.

We have, of course, trephined for many years, probably two thousand or more, for fracture of the skull, with depression, but it is only lately that surgeons have performed that operation for the removal of extradural clots, and in order to ligate the middle meningeal artery followed by drainage. It is within the memory of very young practitioners, since Mr. Harsley, led by the experiments of Munk, Ferrier, Hughlings, Jackson and others, in cerebral-localization, was enabled to diagnosticate an abscess of the motor tract to trephine and drain it.

The new territory discovered for us in this department of our art—cranial surgery—is something glorious to contemplate.

I would class such operations as being conservative, inasmuch as you cannot expect any results from either medication or expectancy. These abscesses or non-specific tumors gentlemen, cannot be removed or absorbed by any remedy, homœopathic or otherwise that I am acquainted with. A rupture of the middle meningeal which is constantly pouring out blood between the duramater and the skull will not be occluded by arnica, either in the 200th or tincture. Such conditions demand surgical assistance and that promptly rendered.

There are a goodly number of diseases classed by the old-school as being incurable medically which we, as Homœopaths, claim to be able to cure by that most difficult of all things to obtain, viz.: “the properly selected remedy given in the minimum dose.” Witness the number of remedies recommended for cancerous affections—for ovarian tumors, cystic or otherwise, even for toothache depending upon an ulcerated root. If we were immaculate—if we could always hit the bullseye at the first shot or possibly the second or third, I would say proceed with your firing gentlemen, even if you do use bullets of small calibre, but I for one cannot make these fancy shots, and knowing another method of ob-

taining the same end and obtaining it at once. I would be recreant to my trust if I did not employ that means. I believe that the knife is a glorious polychrest and the similitum for innumerable diseases.

You can enumerate on the fingers of one hand almost, all the surgeons of our school who have attained eminence in their profession. I do not know why this is so. Surgery is taught in our schools, and the average culture and education of our students is as good, I believe, as in the old school, but the Homœopaths seem to be satisfied to be physicians only, and whenever a case requiring surgical assistance is met with, the friends and relations of the patient take it as a matter of course that an old school practitioner will be called into conduct it. They do not even expect a Homœopath to know anything about surgery, much less to practice it.

These remarks have no particular bearing on my subject, except in as much as they go to emphasize my statement that the Homœopathic school depend so much on medication that they forget the use of the knife almost entirely, and do not employ it with that frequency that it deserves. It is my private opinion, though it may be heresy to say so publicly, that the sooner we are willing to acknowledge that there are some diseases which the properly selected remedy given in the minimum dose will NOT cure, the better it will be for us. If you say that you are ready and willing to make this concession, then I remark that this being the case, you daily in your works of reference, overlook and practically ignore an amount of rubbish or padding which some one, I think, might have the honesty to clear out of our works on *Materia Medica* and therapeutics.

To return to our ruptured meningeal artery. Your diagnosis is made—what is to be done? Obviously your duty is to relieve the pressure due to the blood clot, and to prevent further hæmorrhage; and this you do by trephining, but trephining for fracture of the skull with depression, and trephining for extradural hæmorrhage without fracture, are two entirely distinct things. When you have a depressed fracture all you have to do is to look out for the venous sinuses, go ahead and elevate the bone; but in extradural clot, in abscess or tumor of the deeper seated parts of the brain, where you

require an exact knowledge of cerebral anatomy, that few men possess, you must not only know *how* to trephine, but *where*. Here the results of the men who have made cerebral localization a study become invaluable to us.

The particular spot where the hemorrhage or the abscess or the tumor is located is made known to you first by the peculiar nervous symptoms which follow, and second, or assisted by your knowledge of brain anatomy. You may have all kinds of paralysis or paresis, hemiplegia, paraplegia, anæsthesia, hyperæsthesia, crossed paralysis, monaplegia, numbness, formication, hemian-opsia or anosmia and delayed sensation. The symptoms are legion and while we have yet a great deal to learn before we can locate exactly such lesions, still enough has been done already to enable us to approximate them.

After your clot or tumor has been removed the case is treated on the ordinary rules of surgical procedure. The wound is drained, and if drainage cannot be secured through the first hole made by the trephine, another one is made at the most dependent portion of the skull in reference to the cavity to be drained, looking out of course for the sinuses.

Leaving the head we go down to the chest. Here we find a disease which formerly left to medical men alone is now treated largely by the surgeons, and with the result of conserving many lives. It is namely empyæmia.

Many years ago Dieulafoy invented the aspirator and used it for evacuating the plural cavity of either serum or pus, but it has been found by experience that many times in suppurative pleuritis the pus reforms again with remarkable rapidity.

Cases are reported where truly remarkable quantities of pus have been removed in the course of a few days.

When it is found that the pus tends to accumulate as rapidly as it is removed, then aspiration will do no further good. You must now cut through the chest wall, wash out the cavity and drain. At times it may be necessary to resect a small portion of a rib, but this is not often the case. The operation is not particularly a dangerous one, and seldom fails to give relief though it does occasionally.

The operation is particularly applicable in children. One

minor point which I had very forcibly impressed upon me once is this: that in placing your drainage tube through the incision, you must fasten it firmly to something outside, or the patient is apt, when coughing, to draw it clear into the cavity of the pleura.

This is an awkward accident and might result fatally. A good way of retaining the tube, is to split the external end into three or four slips, and spread each one flush on the chest wall, and retain by adhesive plaster.

These wounds, as a rule, remain open for a long time, but generally heal kindly in the end; and you must not be too anxious to close them.

The customary point of election for entering the pleural cavity, is about on the axillary line between the fifth and sixth ribs, cutting close to the top of the sixth to avoid the intercostal artery.

If the surgeons of twenty-five years ago could see the way in which the peritoneal cavity is now dealt with by their successors, they would truly be astounded. No greater change has taken place in the whole domain of medicine or surgery than the change in our views concerning wounds of the peritoneum. It was taught for years that no matter what the disease, or how severe the wound might be, the surgeon was never, under any circumstances, to enter the abdomen. The patient, might, under certain favoring conditions, survive a gunshot or knife wound of the belly by letting him alone, by paralysing the bowel with large doses of opium and cold externally. Tumors of the uterine appendages or perityphlitic abscess were similarly let alone.

Experience had shown that in almost every instance fatal peritonitis followed, and the surgeon was only inviting death when he entered that forbidden ground.

The treatment of these cases now is almost a diemetric opposite. Instead of entering this cavity, with the fear of death hanging over him, the surgeon nowadays makes exploratory incisions for diagnostic purposes only. He cuts down for the removal of ovarian tumor or disease of the uterus and fallopian tubes, for intussusception of the bowel, for perityphlitic abscess, and for all kinds of wounds of the abdominal viscera. This is indeed a great change. The

bowels now instead of being bound up tightly with morphine, are relaxed by a mild cathartic, the theory for the procedure being, that by opening this great emunctory, it serves as a drain to carry away the "septic material which if allowed to remain would develop septicæmia."—[Wylie.]

I am aware that this procedure is not followed by all laparotomists, but it was introduced and recommended by Lawson Tait, than whom there is none other greater in abdominal surgery.

It may surprise you gentlemen, that in this connection I make no mention of bell, bry, lycop or opium for the relief of peritonitis. I do not refer to these remedies for the reason that I have never seen them do the slightest good for the *kind of peritonitis* to which we are referring. Neither have I ever seen cystic tumor of the ovary disappear after the exhibition of apis or canth or thuja. I do not say that nobody else ever did, only my own short experience has been a negative one, and knowing of a remedy which will relieve this condition I am going to use it.

For what Niemeyer calls "rheumatic peritonitis," or as it is sometimes termed *idiopathic peritonitis*, the remedies alluded to above and others *may* be of avail, but we are not now speaking of that disease; ours is more of a secondary inflammation, or an inflammation following trauma.

I next wish to call your attention to a comparatively new operation which is a model of conservatism. It is Prof. Bigelow's operation of litholapaxy or lithotrity, with rapid evacuation.

We have crushed stones for many years,* but the results were so uncertain that there was but little satisfaction to either the surgeon or the patient. The stone was crushed gradually, requiring many sittings to complete the operation; it was attended with considerable danger, and was very often unsuccessful, inasmuch as it was almost impossible to remove all the debris, and one small particle left behind was sufficient to serve as nucleus for a new stone to form upon. In litholapaxy the calculus is crushed and entirely removed at one sitting; there is, in careful hands, but little danger, and there is no more liability to return than after lithotomy.

*Civiale devised the first lithotrite in 1817.

Prof. Bigelow, when he placed his new operation before the profession, did not discover and announce any new principle in either surgery or mechanics; he simply knew that stones could be crushed in the bladder by employing an instrument called a lithotrite, and he also knew that the bladder could be evacuated and washed out by various different instruments invented by Sir Philip Crampton, Clover and others and he, Bigelow, by putting the two together had litholapaxy. He made, it is true, many improvements on both the crushing instruments and on the evacuator, and to him belongs the credit of placing the operation on a well-recognized basis, so that it is to-day *the* operation for small stones in the bladder.

The consensus of surgical belief now appears to be to crush and revacuate the small calculi and operate by the supra-pubic method for the large ones.

Leaving these greater operations and coming down to something more common, something that any of us are likely to meet in every day practice, minor operations of the fingers, or the face, or possibly an amputation of the hand, or a compound dislocation at the ankle. How does conservatism effect us here?

We will be obliged to specify particularly in order to get at the matter intelligently. Say that you have an injury of the last mentioned example. There is a dislocation of the ankle, the fibula or the tibia, or both protude from the wound, the end of the bones are injured, they may have been driven into the ground with violence. How would you treat such a case?

A few years ago a primary amputation would have been considered the cheapest way out of the difficulty, and so far as the surgeon's reputation is concerned, that man who cuts the most, who has the most major operations, is considered by the public to be the greatest surgeon.

But let me submit to you, which is the better, the surgeon who performs a brilliant operation, who amputates, or he, who by painstaking, careful dressings, by antisepsis, drainage, possibly the removal of small portions of necrosed bone, finally preserves that foot for his patient, even if there is an anchylosed joint, which is the better.

There can be but one answer. It is in compound fractures and dislocations that antiseptic surgery has scored some of her most brilliant triumphs, and it is now the well-recognized rule to attempt at least to save all such limbs, unless the part is almost pulpified, and the large vessels all severed—to make the attempt and if it fails, you can amputate secondarily.

It is astonishing at times from what injuries men will recover, and a great deal of odium has been thrown upon the profession from this very fact.

You will constantly meet men who served in the war of the Rebellion that still carry scars of gunshot wounds they received at that time, and very many of them will tell you: "This leg the doctors were going to cut off, but I just said, gentlemen, that limb stays right where it is, or you can plant the whole of me at once, and there you see it just as good as the other one." Of course, the men who made similar remarks and who died you do not see, for a very obvious reason: still there is no doubt that there was more primary amputating done than was required.

We do things better now, but the particular point I wished to emphasize was, never forget "*Vismedicatrix* (or *conservatrix*) *naturæ*," the healing or preserving power of nature.

Men will often recover from apparently mortal wounds with very little treatment. How much more likely then will they be apt to get well if only nature is given an opportunity to show what she can do, and is assisted by judicious aid rendered at the proper time in a proper manner, instead of an almost apparent antagonism, as has been the custom not many years since.

Take another example—The point of a finger up to last joint has been cut off by a clean cut incision. Many surgeons have recorded instances where by replacing the tip of the severed member and retaining it by a plaster dressing, it has united and good function been secured. I myself remember one such instance, and very many where the distal portion only hung by a tongue of skin.

If the finger or fingers are completely ground into pulp, then the occupation or trade of the person injured will affect your treatment somewhat. If it be a laboring man, you will

use every endeavor to save as much as possible, to conserve for him as many or as much of his members as you can. If on the other hand, it be a young lady in society, then your treatment will be to secure as neat looking stump as can be had under the circumstances. The general rule as to the removal of muscular or osseous tissue, is to be prodigal in removing bone, but sparing of flesh; prodigal of bone because it is seldom that you have more than enough flesh to cover your stump, particularly if the tissues are badly contused, and a good stump is of vital importance on the end of the fingers. You are sparing of flesh for the same reason; you want plenty of tissue for flap. An irritable finger stump is a most troublesome thing, the patient is constantly bruising it, and you will doubtless be called upon to relieve him by a secondary operation.

In injuries to the whole hand the treatment outlined for the digits applies with like force, and the same may be said of the lower extremities.

Save the whole limb if possible, and if you can't do that save as much as you can. The only exception is where you are willing to sacrifice usefulness for beauty. These remarks may appear so like truisms that I must crave your indulgence when I repeat them, but I do so only to emphasize their truthfulness, and to express my belief that they are often overlooked by surgeons who want an operation by which operation they give much eclat and save much trouble.

TREATMENT OF UTERINE DISPLACEMENT.

By A. B. BISHOP, A. M., M. D., SAN JOSE.

[Read before the California State Homœopathic Medical Society, 1888.]

No disease in the whole category is of so frequent occurrence, as that of uterine displacement. Three-fourths of all sick women have more or less dislocation, so-called, of the uterus. It is eminently an *American* disease. No civilized nation can number so many invalid ladies as our own. Indeed it is quite unfashionable for a lady not to have some degree of uterine abnormality.

I do not intend, in this paper, to discuss the character and causes of uterine displacement, but shall confine what little I have to say to its treatment.

First I want to enter a positive protest against all unnecessary interference with the uterus. The less meddling with it the better. The diseased organ resents any disturbance of its condition. Every practitioner tells his patient that she must expect to be worse for a few days, after the first use of the speculum, and after the first topical application; and yet the generality of physicians, particularly the *old-school*, because they place so little emphasis upon the therapeutics, and so much upon local treatment, demand an examination of the uterus, for every little pelvic irritation. The lady, single or married, who has summoned courage to consult a physician, is very apt to be told to assume the genu-pectoral, the supine, or the Sim's position for the examination of her genitalia. If she questions and hesitates, the doctor throws himself back on his dignity, and will have nothing to do with the case, unless she submits entirely to his judgment. Usually her objections are swept away, and the doctor comes out ahead. He may be perfectly sincere and honest in his judgment of what is best, but we think he is mistaken. Many a woman has submitted to months of local treatment for uterine disease which was not there till the meddlesome treatment began, or was there in but a slight and unimportant degree.

Prolapsus uteri is not in itself a disease, but merely a symptom of a diseased system. It is a *result*, and an *index* of a depressed and burdened vitality, an overtaxed and deranged condition.

I grant there are some exceptions, but the exceptions prove the rule. I do not refer to organic lesions, as cancer, myofibroma, laceration or complication with rectal ulcers and abnormal growths. These cases fall in the domain of surgery. But to interfere with speculum examinations and give repeated local treatment for every little deviation or prolapse of the uterus, is no more sensible than to scrape and mop off a furred tongue in order to cure liver and stomach trouble. Indeed the uterus and the tongue are about equally mobile in their respective cavities, and a slight change of

position in one is about as unimportant as in the other. Careful medication will clean off the tongue by correction of the stomach and bowels, so a displaced uterus can be returned to its normal position in the same way, by medication to relieve the depressed vitality and restore the general health.

This explains how certain Homœopathic remedies seem to act as specifics. The patient at the next visit would often exclaim with surprise: "The uterine trouble is better, and my general health is so much better too!"—whereas the pelvic improvement is the result of the other.

I have met with the most *satisfactory* results from the use of internal remedies alone, or aided only by injections and irrigations applied by the patient herself.

In my earlier practice I acted upon the basis, that the main benefit was to be derived from local treatment, from pessaries and appliances, aided secondarily by medication; but I have come to the conclusion after more experience, that the chief good is from careful Homœopathic medication after a strict individualization of the case.

Effects are often taken for the cause. A leucorrhœa, an ulceration, a congestion, or an induration is more frequently the *result* than the *cause* of prolapsus; nay, it is nearly *always* so. And if we claim to cure diseases of the skin without local application, and heal a sloughing and irritable ulcer on the external surface, by internal remedies, is it not logical and consistent to expect to heal an ulceration of the uterus, without topical application.

I believe in ordinary cases far more harm than good is done by pessaries, and speculums, and local application.

Dr. Henry Minton is much more sweeping in his assertions concerning the practice. He says: "I do not believe that uterine displacement of any kind or degree was ever *cured* or even *benefited* by the use of a pessary. It can be easily demonstrated that uterine displacement is not a disease. It is a symptom only, and as such will subside when the cause which induced it has been removed. The causes of which it is but a symptom will, in a large majority of cases, be found to be pelvic cellular inflammation, any interpelvic disorder which diminishes the supports of the uterus, or a local neurosis arising from an impaired or disordered nervous system.

The uterus being a movable organ, is subject to various changes of position. Its mobility is one of its most characteristic features. All its attachments, when in a healthy condition, are such as to admit of the utmost freedom of motion, within certain limits, in all directions. With every motion of the body, even by ordinary respiration, and when coughing, singing, laughing or walking, the position of the uterus is changed. When standing it sinks downward; with the finger it can be lifted up and moved in all directions, and during coition it is elevated to a considerable extent without giving pain. By tight clothing it is forced completely out of its place, without a word of complaint from the subject, or the development of a morbid sign. We are all familiar with what ease and impunity the uterus can be drawn down close to the vulva for surgical interference. The uterus is constantly exposed to forces producing temporary displacements; for instance, the bladder in front, when fully distended, produces complete retroversion, which, though annoying, is seldom painful, and what annoyance there may be comes from the bladder, and not from the uterus. Behind is the rectum, which, when distended, acts also as a displacing cause, operating from above and behind, producing ante-version. From above we have the abdominal pressure, which is constantly acting upon the uterus, and which is greatly increased by every straining effort which brings the abdominal muscles into action, or tension, while below the pelvic floor, has a constant action in supporting the uterus against the pressure from above.

From these facts it will be seen that the uterus may be displaced in any direction, and the causes of such displacements are but natural conditions, which are in constant operation. Thus we may have retroflexion, ante-flexion, ascent, descent, prolapsus, or in fact any decided removal of the uterus from its normal position, while the subject remains perfectly oblivious to the transition.

These displacements are transient and pass away when the conditions which produce them cease to operate. They are, therefore, purely physiological. It is only when the uterus becomes fixed and stationary, failing to return to its normal position, that treatment is called for.

What then is the normal position of the uterus? It has never yet been revealed to man. The very means which we must adopt in studying its topography—the speculum is sufficient to frustrate the end in view. The simple introduction of the finger into the vagina is often sufficient to excite a movement of the uterus. What the anatomist considers a normal position the gynecologist considers abnormal. Hence it is impossible to establish the normal position in health.

As before stated, uterine displacement is *not* a disease, but a *symptom*; the result of uterine and periuterine inflammation, or a local neurosis, arising from an impaired or disordered nervous system, and

First, we have no evidence that uterine displacement alone ever causes local or constitutional disturbances of any kind.

Secondly, we have no evidence that replacement and retention of the uterus in the *supposed* normal position affords any relief from associated with its displacement, excepting the discomforts in cases of traumatism, a sudden shock or fall.

Thirdly, we know by experience that the displacement will disappear with the restoration of the general health.

With this view of the proper treatment of uterine displacement, the duty and policy of the Homœopathic gynecologist becomes plain—to arm himself with weapons from the arsenal of the *Materia Medica*. Close individualization of the case from the totality of the symptoms is the foundation of success in Homœopathy.

OUR PHARMACEUTISTS.

BY L. HENDERSON, SALEM, OREGON.

[Read before the Oregon Homœopathic State Society, May, 1888.]

One year ago, acting on the suggestion of Dr. Emil Hasbrouck, of New York, I called the attention of my colleagues of the Homœopathic Medical Society, of the State of Oregon, to the abuses of Homœopathic Medical Journalism, and, on that occasion, hinted that at some other time I might also have something to say of our Pharmaceutists. The proceedings of the eighteenth annual session, of the Hahne-

mannian Medical Association, of Iowa, furnishes me much food for thought on the subject. At that session, C. H. Cogswell submitted a plea for "Purely Homœopathic Pharmacies," the whole burden of which was that of a complaint that Homœopathic physicians do not properly encourage their pharmacies. Mr. Cogswell evidently thought it necessary to assure the Hahnemannians that he was not a "pharmacist, nor the son of a pharmacist, nor were his sisters, cousins or aunts pharmacists." Most certainly he is to be congratulated if he enters also a like disclaimer of relationship, either approximately or remotely, to medical publishers of the class noticed at our session of 1887.

No one will, for a moment, hesitate to say that it is the duty of every conscientious physician to strive by every means at his command, to elevate the profession of healing, and leave it enriched rather than impaired for those who may follow after. Such preeminently was the characteristic spirit of the immortal Hahnemann, its lustre enlightening every avenue of our professional lives. Under the guidance of that spirit, the physician will seek and *know* his remedy and patient too, and by this marvelous knowledge elevate the standard of Homœopathy. We repeat that to these ends he is not only justifiable, but obligated to bring to bear all the means at his command. Such being the recognized duty of the practitioner, it is in order that we note the discouragements that he must meet and overcome. In this paper we shall notice those adventurers who, under the name of Homœopathic Pharmacists, seek to fatten off the profession, the sick and suffering, while at the same time they are perverting the principles and practice of Homœopathy. We now notice among our pharmacutists a particular class and submit you the query. "Are they deserving of patronage from the standpoint we have assumed?" Every practitioner receives from pharmacies claiming to be exclusively Homœopathic bulletins, price lists and publications, which reveals the fact that these pharmacists are engaged in the dual occupation of conducting a Homœopathic Pharmacy, and vending from the same various nostrums of contraband character. These are offered to the profession and lay patrons. From a close observation we have been able, often, to know who

the purchasers are, and we are prepared to say that they are those who always have been too indolent to study the approved methods of treatment. Such a pharmacy is a necessity only to such a physician, while the latter is a curse to humanity. To contemplate the number of each is not complimentary to the status of medicine.

We are aware that such pharmacies insist that they must live. Wherefore? For what reason? These questions can only be answered favorably to such pharmacies by disregarding the rights of those who should above all others be benefited, i. e., the sick. There are more just reasons why they should not exist:

First. There are more than are necessary.

Second. Out of the fact that there are too many, arises a competition of a character fraught with danger to the patrons of such pharmacies. We are indebted to their own bulletins and price lists for the information that remedies are produced cheaply with little regard to quality.

There are two ways that practitioners can either individually or collectively have much influence in mitigating the evils flowing from this source, to wit:

First. Elevate the standard of medical education. Well educated Homœopathists will have no use for the contraband goods.

Second. Discriminate against such pharmacies in ordering remedies.

ON VALVULAR DEFECTS OF THE HEART.

By PROF. F. RIEGEL.

What is the direct action of valvular defects on the heart? Let us examine the most frequent of all valvular affection, mitral insufficiency and mitral stenosis, and we usually read that their most essential action is an overfilling of the venous system at the expense of a diminished fulness in the arterial system. Clinically we are taught the three symptoms—a systolic murmur, an increased secondary pulmonary sound, and an increased dulness in the cardiac region. Some authors also mention dilatation of the left ventricle. The

same symptoms are also found in stenosis, only with the difference that we have a diastolic instead of a systolic murmur. Why authors consider those murmurs of so much importance is unknown, as it is the most unreliable in the diagnosis of cardiac affections.

Between insufficiency and stenosis, in relation to the disturbance of their physiological action, there is a vast difference. *An insufficiency of a valve does not injure the circulation, nor does it cause an unequal distribution of the blood in the arterial and venous system; it is only useless labor. A stenosis from the very start causes an unequal division of the circulation. Every insufficiency does work which is of no benefit whatever, and every stenosis causes changes in the circulation, and this holds good with all valves.*

Let us consider a mitral insufficiency. With every systole of the ventricle a part of the blood regurgitates into the auricle. Thus the auricle, receiving blood from the pulmonary veins, and by reflux from the left ventricle, becomes over-filled and dilated. With the following ventricular diastole more blood flows from the left auricle into the left ventricle. But all this blood does not flow with the next ventricular systole into the aortic system, only the normal quantity, whereas the plus regurgitates into the auricle in addition to the quantity of the blood normally received by the auricles. But this plus, going and coming from the auricle to the ventricle and back again, is of no benefit whatever to the circulation, and the consequence necessarily is a dilatation of the left auricle and left ventricle, because they contain not only their normal quantity of blood, but an unnecessary plus, which requires secondarily greater labor, of no benefit whatever to the circulation, which may again lead to a moderate hypertrophy. This dilatation and hypertrophy are required for compensation, so that no injury may result therefrom to the circulation. *This dilatation of the left auricle and left ventricle are the primary and direct consequences of mitral insufficiency, the changes in the right heart follow later. But notwithstanding insufficiency of the valve, a dilatation of the left ventricle may not be discovered in the cadaver, and this happens when there is simultaneously a stenosis, which from the very start injures the arterial circulation, as the left ventricle receives then too*

little blood, the left auricle too much. Where there is an insufficiency and stenosis of some importance, a dilatation of the left ventricle will be prevented by the latter. Principally, therefore, every stenosis differs from insufficiency, as in the former the part below the stenosis receives too little blood, thus damaging arterial circulation. But in both, the part lying above the valve, the auricle, becomes dilated. *The same relations which we find in insufficiency and stenosis of the mitralis, holds good also for the aorta and all other valves.*

Every body considers the large vibrating pulse characteristic for aortic insufficiency, which means that with the ventricular systole and arterial diastole too much blood enters the aortic system, but this plus does not benefit the circulation, and regurgitates into the heart. *The same sequelae resulting from aortic insufficiency for the arterial system, must result from mitral insufficiency for the left ventricle.* There the aortic system, here the left ventricle is dilated. There is too much blood during the arterial diastole in the arterial system, here during the ventricular diastole in the left ventricle, and in both cases this quantity of blood fails to be forwarded to the periphery, but always partly regurgitates. We deal, therefore, with "love's labor lost" in mitral and aortic insufficiency, whereas in aortic and mitral stenosis the aortic system receives too little blood. We may put down as an axiom—*Every valvular insufficiency produces dilatation of the parts of the heart lying directly above and below, of the valve which lost the faculty to close up; every stenosis causes from the start a disturbance in the division of the blood, so that above the stenosed valve the blood stagnates, and there is too little blood below it.* We have, therefore, above the stenosed valve, dilatation with secondary hypertrophy; and below, a concentric atrophy. In relation to treatment, we must try in a case of insufficiency to preserve strength, so that the heart can perform this plus of labor, and every pure insufficiency allows therefore, a better prognosis than a stenosis.

It is also of great importance to differentiate between *compensatory dilatation with hypertrophy and disturbed compensation*; the former serves to remove all noxious influences; it compensates the latter, consists of disturbance of circulation, it proves that the heart has not strength enough to

equalize the disturbance; the former must be left severely alone, the latter must be prevented or removed. *Hence, in a pure mitral insufficiency, the dilatation of the right heart must be considered as a proof of an already existing compensatory disturbance.* For a compensation of mitral insufficiency it needs dilatation above and below the insufficient valve of the left auricle and left ventricle; also the hypertrophy of the right ventricle and an increase of the second pulmonary sound, as from the overfulness of the left auricle results an increased pressure in the pulmonary vascular system and hence more work for the right ventricle. But the dilatation of the right ventricle does not belong to the compensation, it only proves that it is unable to hold the balance between the left auricle and the pulmonary vascular system. In every insufficiency, wherever situated, only the parts of the heart lying directly above and below the insufficient valve become dilated, what becomes further dilated presents already a disturbed circulation.

Comparing authorities we find them to disagree in relation to disturbed compensation. When a patient, suffering from heart disease, shows a large liver, severe cyanosis, grave bronchial symptoms, albuminuria, high degree of dropsy and similar symptoms, everybody knows that there is a grand compensatory disturbance. The final act is easily recognized, but we must know *the first symptoms of a beginning compensatory disturbance.* Some mention moderate dyspnoea, others an acceleration of the pulse and slight oedema, all of which may be present, but we must know that the *primary* origin of all compensatory disturbances must be looked for *in the heart* itself, and not in peripheric organs. When the force of the heart fails to equalize the obstacle caused by the valve, a dilatation of a certain part of the heart follows, which we call *dilatation by stagnation* in contradistinction to *compensatory dilatation*, which serves to equalize the obstacle. It is, therefore, of the utmost importance to examine the heart of such patients daily. We must act early to prevent, if possible, the setting in of compensatory disturbances, and the necessary means to that purpose we hope to elucidate in another article.—*Berlin Medical, Wochenschrift*, 20, '88. (S. L.)

SELECTIONS.

MEDICAL EDUCATION.

[*From Dr. N. Schneider's Presidential Address before Ohio State Hom. Med. Soc.*]

The third question for your consideration is that of Medical Education. The subject demands the earnest attention of our Society, and indeed of the whole profession. The time has passed when men and women who are unfit to pursue the study of medicine, should be allowed to enter the office of a preceptor, much less the halls of a medical college. To enter a literary college every student is required to pass a rigid entrance examination. If he fails, he is obliged to further prepare himself, or give it up.

With the advance of science, the requisities of a good physician have increased. It is not enough to have some general knowledge, a common-school education; but the student, on beginning the study of medicine, should have at least a learning that would admit him to a literary college; and the doctor should discriminate, should carefully inquire into the fitness, both as to education and moral character, before he admits him into his office as a student. The preceptor should be the guardian to the door of the profession, admitting only such as are likely to be an honor to the profession, and while we guard the entrance, what shall we demand of our colleges? not that they strive to turn out the greatest number of doctors in the shortest time, but that they admit only those who are properly vouched for, with credentials from some school whose grade of study would permit them to enter the best literary colleges of our land. Demand of them facilities and teachings which will induce the broadest and most thorough medical education.

While you ask this of the colleges they demand of you and your clientage an endowment, that they may employ the best teachers—scientific men—in their various departments; that they may be equipped, not only with good lecture rooms, and suitable apparatus, but also possess all the facilities for illustrating and pursuing the various departments taught.

You endow literary colleges and theological schools. They select for their teachers the ablest men the land affords, and pay them for it; but our poor medical schools are obliged to struggle on in poverty, without sufficient apparatus to illustrate, without facilities for teaching, without money to pay a faculty, demanding of men who are overworked by the exacting duties incident to a busy practitioner's life, men who are obliged to sustain themselves and families by hard work, with minds robbed of their freshness by incessant toil and sleepless nights. I say you demand of them that they prepare men for this learned profession.

It is more important that men be better educated in the theories of theology, than they who devote themselves to the science of medicine?

Shall the education of men who have the physical welfare of our people in their hands be less provided for? Men who are expected to understand anatomy and physiology — that when tissues are diseased or functions disturbed they may be able to set them right? Men who are expected to understand the science of sanitation, that our homes may be protected from fierce epidemics, and the portals of our country guarded from the destroying angel of pestilential disease?

Should not every facility be given for their education? And yet members of the theological profession, enter the homes of your wealthy clients, secure bequests for their seminaries, even while you are administering to their physical sufferings, alleviating their pains, and as far as possible, giving them a comfortable exist from this world, and, perhaps, a happy entrance into the next. Would it not be well for us, as we love our profession, to wake up to the financial condition of our colleges. We have two worthy ones in this State, which are doing their best to educate the men who come to them.

Neither college has an endowment, both depend upon the fees they get from the students to meet their financial demands; and some of you ask smaller fees for your students, and search the country over for colleges which give cheaper lectures, and push them through in the shortest possible time. Let us endow *our* colleges—it can be done. Give something yourselves. Ask that friend, whose ills you have

cured, whose life you may have saved, by whose bedside you have watched and struggled to avert the fatal issue. Ask your friends for money to endow our colleges. Your cause is as worthy as the theologian's, be not backward, it is a glorious work. And, gentlemen, I have no doubt, if we work half as earnestly as our theological brethren do for their seminaries, you will see our old college at Cleveland, and our younger one at Cincinnati, liberally endowed; their lecture rooms spacious and comfortable; their laboratories equipped; their libraries filled with the best medical literature, and the various chairs so endowed, that the trustees will be able to secure the ablest and wisest instructors, and the clinical department enriched with larger and well-endowed hospital wards. Would it not be well for the Committee on Education to organize this work, and try what can be done?

OPHTHALMOLOGY AND OTOTOLOGY.

DEPARTMENT CONDUCTED BY H. C. FRENCH, M. D.

The following extract from a letter to one of our editors offers many instructive hints as to the methods of operating in the large hospitals of London.

“As I have seen a great many very interesting and instructive eye operations since I have been here, it would seem rather selfish not to let you share the paper and pen sight of some of those which I saw yesterday at Moorfield's Royal London Ophthalmic Hospital.

Case I.—Operated by Mr. Tweedy. A young woman who had a very decided conical cornea, with greatly reduced visual acuity, was placed upon the couch, cocaine having been previously instilled into the left conjunctival sac. The lids were held apart with a stop speculum. The eye was fixed by means of a pair of forceps which was held in the left hand; in the right a Beer's knife; with this the apex of the cone was scraped quite thoroughly; the space thus treated was nearly two lines in diameter.

Next followed the galvano-cautery point. This was brought to a cherry colored heat and drawn very lightly across the cornea two or three times, until the whole of the denuded surface had been cauterized. When Mr. Tweedy thought that about half the thickness of the cornea had been destroyed the operation was concluded with a drop of cocaine, 2 per cent. solution. No fixation was employed during the cauterization process, and at no time was there any pain experienced. Mr. Tweedy has operated in but three other cases by this method, and his past experience leads him to believe that this new method will gradually take the place of the trephine and the excision of the cone. In the milder cases he still prefers the frequent punctures.

The following case was that of a woman aet. 65 years. The left eye had been totally useless for a long time, and recently panophthalmitis had set in. The conjunctiva was still greatly engorged, and a marked peri-corneal injection existed. The cornea was opaque throughout.

The anæsthetics — chloroform followed by æther — were given, and the eye enucleated. Small bands of adhesion passed from the cellular tissue to the globe, the result of recent cellulitis which had not entirely subsided.

After the globe was removed the wound was thoroughly syringed with a 5 grain solution of zinc chlor. A tight bandage over a sponge was applied. Instructions were given to remove the dressings as soon as possible after the arrest of the bleeding, owing to the danger of increased infiltration and cellulitis from the pent up discharges.

The other cases which Mr. Tweedy presented were not particularly instructive, but not so with two of Mr. Lawson's cases, which I will try to describe briefly.

The first was a cataract extraction in a man 70 years of age. After the left eye was cocainized, a spring speculum was inserted, but no fixation was employed for the section; this was made with a stiff von Graefe knife held in the left hand. The middle finger of the right hand was placed against the nasal side of the globe near the point of counter puncture. The section was made well within the cornea, at the sclero-corneal junction.

An assistant was requested to fix the eye while the iridectomy was performed; this over, a curved, flat and sharp pointed probe was used as a cystotome to lacerate the capsule. The last part of the operation, viz: the extraction of the lens, proved the most instructive. A shell curette was taken in the right hand and placed against the sclerotic conjunctiva below the cornea; a metal curette was held in the left hand, against the sclerotic, above the incision. Alternate pressure with these instruments failed to present the lens. The capsule was then more thoroughly lacerated, this time at the periphery with a von Græfe knife.

Upon a second trial of the alternate pressure, the large, hard lens was forced into the wound; but even though it was a good sized section, the lens was too large to be forced out. With the shell curette placed against the cornea, the cataract was held between the lips of the incision, while it was lifted out with the cystotome, which had been gently insinuated into its substance.

The pupil was left clear and black. As the angles of the wound were clear, the eye was closed and a pad of prepared cotton placed upon it and its companion, over these a single bandage was placed, and the man rising from the couch, was led out of the room.

The next case was that of a boy eighteen months old. Congenital cataract had existed in both eyes; the left one had been needled and most of the lens had been absorbed, but the capsule was very thick and opaque, on which account the child was chloroformed and the capsule lacerated.

The first needle was inserted while held in the left hand, and made to push against the capsule which was so dense that it could, with great difficulty, be punctured. It was impossible to tear it, and on that account a cutting stop-needle was taken in the right hand, and with much effort forced into the capsule by the side of the first needle.

After this it was not difficult to tear the capsule and give a good, dark, central—though small—opening. No lens matter escaped, but the small amount that was in the sac would soon yield, no doubt, to the action of the aqueous humor.

A pad of dry cotton was placed over the eye, and a single strip of bandage material tied over it.

Were I to attempt to describe all of the operations which one sees at Moorfield's in a single week, I should make you feel that all of the eye surgery of England, and all of her possessions, was done in that institution; but such is not the case, for while it is conceded the largest ophthalmic hospital in the world, there are, in London, even some very large eye clinics at the general hospitals, as well as at other institutions devoted alone to the treatment of eye diseases.

While London is a great field for observation for the practicing specialist, it is not conducive to the preliminary studies of the itinerant student, as but little instruction is given without considerable questioning, save in the case of a few surgeons who are ever ready to impart a goodly share of their hard-earned store of knowledge. The student will find vast opportunities for clinical instruction on a grand scale in Vienna, as you know, and as good opportunities for clinical observation in London. Yours, very truly,

HORACE F. IVINS."

Colleges, Hospitals and Societies.

OREGON STATE SOCIETY.

The twelfth annual session of this Society, held on May 8th, 9th and 10th, at Portland, was of unusual interest and profit to those present. Amongst the most important papers read were: "Spongia Tosta," by Dr. Geo. Wigg; "Tarantula Cubensis," by Dr. A. Pohl; "Aconitum Napellus," by Dr. S. A. Brown; "Our Pharmacists," by Dr. L. Henderson; "Vesico Vaginal Fistula," by Dr. B. E. Miller; "The Insane and their Proper Treatment," a very interesting paper by Dr. Osman Royal, which appeared in the daily papers in full; "Tubercular Meningitis," by Dr. Emma J. Welty; "Bacteria as a Cause of Disease," by S. Lewis King, M. D.; "Iritis," by E. C. Brown; "Diseases of the Lachrymal Duct," by A. S. Nichols, M. D., etc.

The following resolution was passed, which is of interest to our California members:

Resolved, That the Homœopathic Medical Society of the State of Oregon extends to the Hahnemann Hospital College of San Francisco, its most cordial congratulations because of the steps taken in its organization to elevate the standard of medical education by restricting its choice of matriculates to such as have the requisite literary qualifications, to study medicine intelligently, and by restricting the number of its alumni to those only who have successfully prosecuted a three years course of study.

Upon completion of the new hospital (allopathic) in Portland, arrangements have been made securing to Homœopaths and their patients equal privileges, wards, medicines, nurses, etc., all to be under the exclusive control.

HAHNEMANN ÆSCULAPIAN SOCIETY.

The above Society held its first regular meeting for the term of '88, on Thursday evening, June 7th, in the lecture room of the College.

The announcement that Prof. Wm. Boericke, M. D., would address the meeting, brought out the members and their friends in such numbers that the seating capacity of the hall was insufficient.

The meeting was called to order by the President, and after the order of business had been disposed of, Prof. Boericke was introduced, and taking for his subject "Natural Law for Healing," he favored the audience with an enjoyable hour, duly appreciated.

The President then announced that at the next meeting, to be held July 5th, Dr. Minnie C. T. Love would address the Society; subject, "The Physician as an Educator of the People." Adjourned.

FIFTY YEARS A PHYSICIAN.

Prof. S. Lilienthal, who is delivering a course of lectures on the organon and nervous diseases in Hahnemann Hospital College, as he entered the clinic room on June 7th, remarked: "this is the anniversary of my wedding to my profession."

Fifty years ago to-day, I received my diploma, and a happy boy I was that day." The group of students crowded around with handshakes and congratulations, for the veteran standard bearer of Homœopathy is a great favorite among them, and one suggested that the hour usually devoted to the intricacies of medical science could, that day, be as profitably spent in listening to an outline of a professional life, which has comforted and blessed so many other lives, and ever reflected honor upon the principles of the illustrious Samuel Hahnemann. This proposition met with such hearty applause that the professor could only take his place upon the rostrum, and begin his story with his life in the native town of Munich in the gymnasium, where, with other boys as bright and jolly as himself, he studied history, mathematics, science, Greek and Latin, always maintaining a high standing in all but the classics, which were less to his taste. Graduating from the gymnasium with honors he entered the University, where he devoted himself to the study of medicine for six years, (an Allopathic college of course). Here every branch but that of surgery proved congenial, and we will call the attention of our students to the fact that his study of anatomy by the aid of dissections was pursued with a thoroughness and perseverance that gives us a clue to his present skill in treating nervous diseases. Not content with going over a part once or twice but many times, and with the aid of the microscope as well as his own good eyes, he traced out the courses of nerves—his pet pneumogastric coming for a good share we promise—and their possible functions. In his devotion to the acquirement of knowledge, the social life of the University was not altogether neglected. He was, at times, ready for a frolic as well as the rest, could defend his opinions with a practical demonstration of the flexors and extensors, if necessary. At last the happy years of student life drew to a close, and, like poor students of other climes and later days, in much fear and trembling, he went up for his final examinations. Stage struck at first he could not find the ready answers his professor knew were there, but speedily recovering himself he went on, finally passing with highest honors. In the German university the end is not here, but the unhappy student must write a thesis

on some abtruse subject, and he was made further wretched in being obliged to present and defend it before a crowd of professional critics, and woe betide the poor fellow who does not know whereof he states or presents a defective argument. Not so was it with our student, victorious here as in all else, he received the commendation of the faculty and his precious sheepskin. After a course in hospital work he began a career in Munich which soon gave promise of success, but at this juncture a friend announces a determination to come to America, and inspired by an ambition to try life in a new country the young doctor suddenly decides to accompany him. Leaving home and friends with a somewhat slim purse, for he is independent, this brave, sturdy young fellow!—he starts for this country in a sailing vessel. He has the good fortune to be appointed ship surgeon, and makes the seven weeks' voyage in safety.

Arrived in New York, he had letters of introduction to a physician at Allentown, Pa., and finding the stage journey thither an expensive one for his slender purse, he walks the entire distance. He is kindly received, and recommended to a physician in need of an assistant. His early experiences in America were rather severe, but success in practice always attended him, and from his income, however small, he always laid by a portion for a rainy day. The hard work proved too much after a time, and he was prostrated by a severe illness. Recovering from this in a measure, he sought the more congenial climate of the Southern States. There he found health and work, and there he brought his young wife. He had soon a good practice, and life assumed a pleasant aspect to him. After a few years he found, however, the climate did not suit his wife, and for her sake he relinquished his hopes in that field, and coming to New York, located in a town on the Hudson. Very soon again success crowned his efforts. When in an epidemic of scarlet fever he became convinced that his mode of practice was not the best; that the Homœopaths were doing what he could not, and that there was something in Homœopathy that he did not know and must find out. With his usual honesty and singleness of purpose, he made up his mind as to his course. Relinquishing his practice at once, he retired to a small town, where for two

years he devoted himself to the study of the Homœopathic Materia Medica. "This," said he, "was the only time in my life when I thought I knew my Materia Medica, I have found out since, I never can know it." Again he returned to New York City, and his career there is so well known to all loyal Homœopaths that it is needless to go over the ground here. For years a valued and honored professor in the New York Homœopathic College and in the Homœopathic College for Women, connected with Middletown Asylum for the insane, and editor of the *North American Journal of Homœopathy*, he accomplished a work and made a reputation which will live after him. We Californians are wholly indebted to our more genial climate for his presence here. He is following out his favorite work, and the students of Hahnemann Hospital College are indeed favored in having such a teacher. As the bell rang to announce the close of the brief hour, the Professor said: "I shall soon be done with life, bury me or cremate me as you will, but don't forget me." Prolonged applause and not a few moist eyes attested to the appreciation of his audience. Later in the day a superb basket of roses was sent by the senior class to the Professor's residence.

STUDENT HAHNEMANN HOSPITAL COLLEGE.

CORRESPONDENCE.

LETTER FROM TRUCKEE.

TRUCKEE, May 22nd, 1888.

EDITORS CALIFORNIA HOMŒOPATH: Being a friend and advocate of Homœopathy as well as a student in medicine, I write to inform you that in *my* opinion there is a good opening here for a good physician of steady habits. We have two physicians of the old school here. Both are unpopular.

I think you would safely recommend this place to any one looking for a location. Any other information wanted in *my* power to give will be cheerfully given. Yours respectfully,

DR. D. W. BEVERTON.

The California Homœopath.

A MONTHLY JOURNAL,

Devoted to the cause of Homœopathy on the Pacific Coast. The only Homœopathic Medical Journal west of the Rocky Mountains.

EDITORS. - - WM. BOERICKE, M. D. and W. A. DEWEY, M. D.

PUBLISHERS, BOERICKE & SCHRECK.

Subscription Price, \$2.00 per annum, in Advance. Single Copies, 25 cents.

ADVERTISING RATES.

SPACE.	3 Months.	6 Months,	9 Months,	1 Year,
One Page.....	\$25 00	\$40 00	\$60 00	\$75 00
Half Page.....	15 00	25 00	30 00	40 00
Quarter Page.....	10 00	15 00	20 00	25 00

Address all Communications, Exchanges, Books for Review, to

THE CALIFORNIA HOMOEOPATH, No. 234 Sutter St., San Francisco, Cal.

EDITORIAL.

BEFORE this journal reaches the hands of its readers the forty-first meeting of the oldest national medical association that this country can boast of will be a thing of the past. The success of this meeting was assured beforehand by the energy and labors of the men at the helm. The particulars are too late for this issue, but we hope in our next to have something to say about it. It seems to us that a reform should be instigated in regard to the place of meeting. Our National Society should be more national and not so much New Yorkian. The last three meetings were successively held in that State; indeed, five out of the last eight meetings were held in New York. The Committee upon Place of Meeting should bear San Francisco, Denver, Minneapolis, etc., in mind; all are available places for the forty-second meeting.

NOTE.—Owing to press of other matter we omit the “Popular Department” this month.

Personal Notes, Locations, Etc.

DR. H. J. SUTTLE has located in San Diego.

DR. ANNA E. BAILY has located in San Francisco.

DR. J. N. SWASEY, formerly of New York, has located in Alameda.

DRS. SAMUEL and J. E. LILIENTHAL have moved to their new quarters, No. 1316 Van Ness Avenue.

DR. B. F. FOOTE, of Stanford, Conn., is at present on this coast. He will spend the winter in Alameda.

DR. J. P. FULLER, of Modesto, has been among us for a few days, taking a needed rest from the cares of a large practice.

DR. W. A. DEWEY, has removed his residence to 1133 Bush Street. Office, 834 Sutter street, as heretofore.

DR. R. CARTWRIGHT, of Grass Valley, recently paid us a call. The doctor reports Grass Valley to be booming and Homœopathy flourishing.

DR. JOHNSON, of the firm of Johnson & Stiles, the well known Homœopaths, of San Bernardino, has been spending a few days in this city.

DR. GUY, formerly of Brooklyn, N. Y., one of the oldest Homœopaths in the country, has located in San Francisco, and has opened an office at 814 Sutter Street.

DR. J. N. ECKEL will resume his admirable lectures on Paedology early in July. During his absence DR. S. LILIENTHAL and DR. WM. BOERICKE filled the vacancy.

DR. AMY G. BOWEN has returned from New York, where she has passed the winter pursuing her studies. The doctor is enthusiastic over New York as a medical centre—in fact as a centre for anything.

DR. GEO. E. DAVIS, President of the California Homœopathic State Board of Examiners, is at present among the deer and trout of Siskiyou and Shasta counties. This explains why there is no list of new licentiates in this number.

MR. WM. A. BROOKS the efficient manager of Boericke & Schreck's Homœopathic Pharmacy who has been spending his vacation among our southern coast counties, has returned, and is replete with information as to good locations, status of Homœopathy etc., in said counties.

PROF. ADLEY H. CUMMINS, of the chair of Medical Jurisprudence at the Hahnemann Hospital College, has a card in this journal, and an office at No. 507 Montgomery Street. The Professor sees that his clients receive law in Homœopathic doses, hence those who do not wish to be drugged with law and lawyers cannot do better than to put their law matters into his hands.

NOTE:—We desire to call the attention of our readers to a number of new advertisements appearing in this number, as well as several changes in old ones. The liberal offer made by the *Medical Era*, *The North American Journal of Homœopathy*, and the seasonable notice of that favorite food *Bovinine*, will repay perusal.

BOOK REVIEWS.

A Repertory of Gonorrhoea. Compiled by SAMUEL A. KIMBALL, M. D., I. H. A. Published for the International Hahnemannian Association. Otis Clapp & Son, 1888.

The arrangement of this little book is like all similar attempts emanating from the I. H. A., purely mechanical. It assumes every recorded symptom in the ten volumes of Allen, plus sundry other volumes, to be revealed truth to the suffering humanity, every jot and tittle of which must be preserved. These separate symptoms are arranged under different heads for ready reference. The differentiation goes on to an appalling degree, thus we find separate recognition being given to "stitching in the urethra," and to "stitches in the urethra."

We do not believe that such a mechanical arrangement leading to merely mechanical covering of symptoms is conducive to the true apprehension of our *Materia Medica*, nor to the speedy healing of a poor victim suffering with gonorrhoea.

Foreign Sketches; Chiefly notes from the German Eye Clinics. By HAROLD WILSON, M. D. Reprinted from the *Medical Advance*.

A most enjoyable and suggestive half hour's reading, for which we are greatly obliged to the author.

Publications of the Massachusetts Homœopathic Medical Society, 1887; Vol. X. Boston, 1888.

Another valuable addition to the list of transactions of our State Societies. Among the interesting papers which abound in this volume, is a complete one on Diabetes Mellitus, also a series on Pneumonia in children. The *Materia Medica* department gives a new proving of Apis, and a comparative study of Bryonia and Phosphorus. Besides, these papers on Surgery, Gynæcology, add to the value and interest of the volume.

Photographic Illustrations of Cutaneous Syphilis. By GEORGE HENRY Fox, M. D. Parts I and II. E. B. Treat & Co., N. Y.

This work is a worthy companion to the excellent and well known photographic illustrations of skin diseases, by the same author. It is to be complete in twelve numbers, and should be procured by every physician who has the dermatological series, and we believe most of our schools have them.

An Ephemeris of Materia Medica, Pharmacy, and Therapeutics, and Collateral Information. By Drs. SQUIBB, Brooklyn. June, 1888.

President A. C. Cowperthwaite's Circular, relative to the American Institute of Homœopathy.

Annual Circular of the American Institute of Homœopathy; for the session 1888, to be held at Niagara Falls, N. Y. June 25th to 29th.

Zum Capitel der Krankheiten der Gallen—und Harnorgane und ueber Entfettungs Kuren, von Dr. Theodor Kafka, Karlsbad.